LOUISVILLE METRO PUBLIC HEALTH & WELLNESS

SPECIALTY CLINIC REGISTRATION FORM

05-12-2014 REF:

There may be additional charges at the end of your visit.

****If you have State Medicaid, Medicare, Passport or Private Insurance, please give cards to clerk.**

PLEASE TURN THIS PAGE OVER

Date of visit: _____

Name: _____, _____
Last First Middle Initial

Social Security #: _____-_____-_____

Birth date: _____/_____/_____
Month Day Year

Address: _____

_____(_____)_____
City County State Zip Code

Home Phone: (___) _____ **Cell Phone:** (___) _____

Emergency contact: _____ **friend / relative** **Phone:** (_____) _____

PLEASE NOTE: If you are currently on your menstrual cycle, you can not be seen for an exam.

FOR ADMINISTRATIVE USE ONLY

Paid: _____

Due: _____

Medicaid: _____ **Medicare:** _____

Passport: _____ **Private Ins.:** _____

Age _____

Sex:
Male ☐ **Female** ☐

Race:
Asian ☐
Black ☐
Hawaiian ☐
Hisp. /Latino ☐
NativeAmer. / Alaskan ☐
White ☐
Other: _____

Marital Status:
Single ☐
Married ☐
Divorced ☐
Separated ☐
Widow(er) ☐

Have you been in this clinic before?
No ☐ **Yes** ☐

If yes, when: _____ _____
Month Year

Why are you here today? (Check services needed):

STD Exam Only ☐
HIV Test Only ☐
STD Exam incl. HIV Testing ☐
Syphilis Testing Only ☐
Herpes Culture ☐ **(not a blood test)**
Warts ☐

Received a call from us (Do you know the name of the person who called you: _____

Other: (Please Specify) _____

_____

LOUISVILLE METRO PUBLIC HEALTH & WELLNESS

Patient Name:_____

DOB:_____

ID Number:_____

Specialty Clinic HISTORY AND PHYSICAL EXAM

What is the main reason for your visit today? ☐ No Complaint ☐ Discharge ☐ Odor ☐ Sores
☐ Pain when urinating ☐ Pain in genital area ☐ Rash ☐ Bumps ☐ Burning when urinating ☐ Genital Itch
☐ Testicle pain ☐ My partner had?_____ ☐ Other:

When did your symptoms start?

What have you done to relieve symptoms?

Are you allergic to any medicines or foods? ☐ Yes ☐ No If yes, please list:

Current medications: ☐ None ☐ Calcium ☐ Multivitamin ☐ Folic Acid ☐ Other:

Alcohol or Street Drugs: ☐ None ☐ Seldom: Type_____ ☐ Occasional: Type_____
☐ Frequent: Type_____

Abuse/Neglect/Violence: ☐ Pressure to have sex ☐ Forced sexual contact ☐ Fear of verbal/physical abuse
☐ None ☐ Daily needs not met ☐ Anonymous partners ☐ Sex for money or drugs

Sexually active with: ☐ Males ☐ Females ☐ Both

Number of partners: In the past month:_____ In past 2 months:_____ In past 12 months:_____

IN THE LAST 60 DAYS

Date of last oral sex:_____ given/received/both Partners: ☐ Male ☐ Female ☐ Both

Date of last genital sex (penis to vagina) _____ Partners: ☐ Male ☐ Female ☐ Both

Date of last anal sex:_____ given/received/both Partners: ☐ Male ☐ Female ☐ Both

Do you use condoms: ☐ ALWAYS ☐ SOMETIMES ☐ NEVER

BIRTH CONTROL: ☐ None ☐ Pill_____ ☐ Depo ☐ IUD ☐ NuvaRing ☐ Patch
☐ Foam ☐ Implanon ☐ Vasectomy ☐ Tubal Ligation ☐ Other:_____

Date of last HIV Test:_____

FEMALES ONLY:

First day of last menstrual period:_____
☐ Regular ☐ Irregular

☐ Menopausal ☐ Endometrial ablation ☐ Pregnant
☐ Hysterectomy ☐ Other:_____
Are you trying to get pregnant? ☐ Yes ☐ No

When was your last PAP? _____ ☐ Never
Was the result normal? ☐ Yes ☐ No Explain:

Do you douche? ☐ Yes ☐ No

pregnancies_____ # live births_____

_____ Patient Signature

_____ Date

STOP HERE. DO NOT WRITE BELOW THIS LINE

PREVENTIVE HEALTH EDUCATION: Check counseling topics discussed today

☐ STD	☐ Risk Reduction	☐ ATOD cessation	☐ Mental Health	☐ Minor FP Patient counseling- sexual coercion. Abstinence. Benefits of parental involvement in choices
☐ HIV	☐ Condom use for STD	☐ Preconception/Folic Acid	☐ Pelvic/PAP	
☐ HIV Pretest	☐ Condom use for pregnancy prevention	☐ SBE/Mammogram	☐ STE/PSA	
☐ Partner Notification		☐ DV/SA/Abuse	☐ Family Planning	

Educational Handouts: ☐ STD ☐ HIV ☐ FP ☐ Other

Healthcare Provider Signature Date:

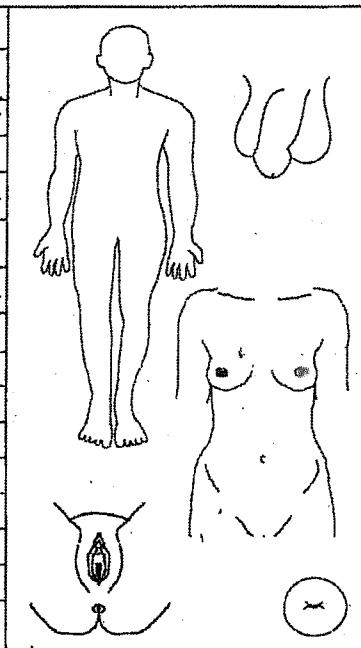
DIS/Health Educator ☐ Pretest HIV ☐ Posttest HIV

Signature: ☐ Other:

Patient Label

OBJECTIVE: General Examination

SYSTEM		NL	ABNORMAL
Constitutional	GENERAL APPEARANCE		
HEENT	HEAD: SCALP		
	EYES:		
	MOUTH:		
Gastro-intestinal	Abdomen		
	Anus/Perineum		
Genito-urinary	Male Genital Area		
	Scrotum		
	Testes		
	Penis		
	Female Genital Area:		
	Vagina		
	Cervix		
	Uterus		
	Adnexa		



SYSTEM		NL	ABNORMAL
Lymphatic	Neck		
	Axilla		
	Groin		
Skin/SQ Tissue	Inspection (rashes)		
	Palpation (nodules)		

BLOOD DRAWN: ☐ RPR ☐ FTA

HIV: ☐ ACCEPTED ☐ DECLINED ☐ N/A

BLOOD DRAWN BY:

LAB:
- ☐ GRAM STAIN
- ☐ WET MOUNT
- ☐ KOH
- ☐ RPR
- ☐ TZANCK
- ☐ DFE

OTHER:

TESTING TODAY:

- ☐ GC/Chlamydia Swab ☐ Urethral ☐ Cervical
- ☐ GC/Chlamydia Urine
- ☐ GC Culture Oral ☐ GC Culture Rectal
- ☐ HIV Blood ☐ HIV Oral
- ☐ Herpes Culture ☐ Wet Mount
- ☐ Other:_____

COMMENTS/EXPLANATIONS

IMPRESSIONS:

☐ NO APPARENT STD ☐ GONORRHEA ☐ CHLAMYDIA ☐ TRICHOMONIASIS ☐ NGU ☐ MPC
☐ BACTERIAL VAGINOSIS ☐ VAGINITIS ☐ CANDIDA/FUNGAL ☐ HERPES ☐ WARTS ☐ SYPHILIS_____
☐ MOLLUSCUM ☐ CRABS ☐ SCABIES ☐ CHANCROID ☐ FOLLICULITIS ☐ CERVICITIS
☐ PID ☐ CONTACT TO: _____

TREATMENT: ☐ NONE

- ☐ Twinrix_____ INJ TIME:_____ SITE:_____ MFG:_____ LOT #:_____ EXP DATE:_____
- ☐ Bicillin 2.4 mu IM X 1 2 3 INJ TIME:_____ SITE:_____ MFG:_____ LOT #:_____ EXP DATE:_____
- ☐ Ceftriaxone 250 MG IM INJ TIME:_____ SITE:_____ MFG:_____ LOT #:_____ EXP DATE:_____
- ☐ Azithromycin 1 GM PO
- ☐ Azithromycin 2 GM PO
- ☐ Metronidazole 500 MG PO BID X 7 DAYS
- ☐ Metronidazole 2 GM PO
- ☐ Doxycycline 100 MG BID PO X_____DAYS
- ☐ Terconazole Cream QHS X 7
- ☐ Nystatin Cream BID X 7 – 10 DAYS
- ☐ TCA provider applied to genital warts
- ☐ Acyclovir 400 MGPO Q8 HRS X 5 DAYS RX
- ☐ Miconazole Cream QHS X 7 DAYS
- ☐ Permethrin topical – use as directed
- ☐ Counseled on Benefits, SE and adverse reaction to medications given.
- ☐ Other:_____

Recommendations made to client, for scheduling of follow-up testing and procedures, based on assessment: ☐ N/A

- ☐ Vision/Hearing
- ☐ Speech
- ☐ Dental
- ☐ Hgb
- ☐ Sickle Cell
- ☒ Lead
- ☐ UCG/HCG
- ☐ Developmental Scr. Tests
- ☐ JADAC
- ☐ Other:
- ☐ FBS/GTT
- ☐ Lipid Screen
- ☐ Pap Smear
- ☐ Mammogram
- ☐ Ultrasound
- ☐ TST/CXR
- ☐ Liver Panel
- ☐ Urology
- ☐ Colorectal surgery

Referrals Made: ☐ N/A

- ☐ PCP
- ☐ Pediatrician
- ☐ Radiology
- ☐ MNT with RD
- ☐ Medicaid
- ☐ Social Svcs
- ☐ Hands
- ☐ WIC
- ☐ FP
- ☐ 1-800-QUIT- NOW
- ☐ Cooper Clayton Classes
- ☐ Other

Provider's Signature: Date: Recommended RTC:

REGISTRATION, AUTHORIZATIONS, CERTIFICATIONS AND CONSENTS

Place #1 label of registration here	*Place #3 label of Registration here*
Place #2 label of registration here	*Place #4 label of registration here*

Is it OK for us to use an automated telephone message to remind you of your appointments? ☐ **Yes** ☐ **No**

FINANCIAL CERTIFICATION:

☐ I certify that my answers are correct and complete to the best of my knowledge and I have reported all my household income, KTAP, Medicaid, and Food Stamp benefits to determine program eligibility. I understand that I may be asked to provide proof of household income, KTAP, Medicaid, and Food Stamp benefits.

☐ I understand that some of the health department's fees for service are based upon ability to pay which is determined by an assessment of household income. Since I prefer not to supply this information I agree to pay full charges.

Signature of Patient or Authorized Person	Date	(WITNESS Signature, *if person cannot sign*)
Signature of Patient or Authorized Person	Date	(WITNESS Signature, *if person cannot sign*)

PAYMENT FOR SERVICE/ASSIGNMENT OF BENEFITS ***MUST be signed for every patient who has a third party payor. Name of health department MUST be SPELLED OUT.***

☐ **ASSIGNMENT OF BENEFITS:** I request that payment of authorized medical insurance benefits be made to _____ on my behalf, for services I received. I also authorize the local health department to release medical information about me to Medicare, insurance and other third party payors to determine payment for services. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third party payors pursuant to KRS 214.420.

I have read the above and have had an opportunity to ask questions. I understand the item checked above as it applies to me. My signature below indicates I do consent, authorize or declare as stated above.

Signature of Patient or Authorized Person	Date	(WITNESS Signature, *if person cannot sign*)

GENERAL CONSENT FOR HEALTH SERVICES (***expires 1 year from date signed, unless change in custody***):
Of my own free will I consent to care which may include screenings, exams, lab tests, treatments, medicines, x-rays, and any other health service given to me or above named individual by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any exam or treatment on me or above named individual. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed for a diagnosis, to assist in my or above named individual's treatment, or if a health care worker is exposed to my or above named individual's blood, body fluids or tissue as applicable by law.

Signature of Patient or Authorized Person	(WITNESS Signature, *if person cannot sign*)
(Relationship to the patient, if not self)	Date

GENERAL CONSENT FOR HEALTH SERVICES BY FOSTER PARENTS OF MINORS IN CUSTODY OF THE CABINET FOR HEALTH AND FAMILY SERVICES (***valid for 1 year from date signed, unless change in custody/foster parent or invasive procedure required***): Of my own free will I consent to health services, for the minor child of which is currently in my foster care, given to the above name individual by staff or agents of this health department. ***I understand that I am not allowed to consent to any invasive procedure services as defined by 201 KAR 20:235, Section 1(6) for the above named individual.*** I understand that no Guarantees are being made as to the effect of any exam on the person for whom I am consenting.

Signature of (CHFS) Foster Parent	Date

WIC RIGHTS AND RESPONSIBILITIES (*MUST be signed at every WIC certification and recertification.*)

I have been advised of my rights and obligations under the WIC program. This includes the rights and responsibilities for the eWIC card and any household benefits issued to the cardholder account. I understand that I am also responsible for ensuring the security of the eWIC benefits card and the PIN. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification form is being submitted in connection with the receipt of Federal Assistance. Program officials may verify information on the certification forms. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the state agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law. I have been issued I also understand that my name may be given to other health and welfare programs for eligibility purposes for that program.

Signature of Patient or Other Authorized Person	*Date*

REGISTRATION, AUTHORIZATIONS, CERTIFICATIONS AND CONSENTS

Place #1 label of registration here	*Place #3 label of Registration here*
Place #2 label of registration here	*Place #4 label of registration here*

Is it OK for us to use an automated telephone message to remind you of your appointments? ☐ **Yes** ☐ **No**

FINANCIAL CERTIFICATION:

☐ I certify that my answers are correct and complete to the best of my knowledge and I have reported all my household income; KTAP, Medicaid, and Food Stamp benefits to determine program eligibility. I understand that I may be asked to provide proof of household income, KTAP, Medicaid, and Food Stamp benefits.

☐ I understand that some of the health department's fees for service are based upon ability to pay which is determined by an assessment of household income. Since I prefer not to supply this information I agree to pay full charges.

Signature of Patient or Authorized Person _____ **Date** _____ **(WITNESS Signature, *If person cannot sign*)** _____

Signature of Patient or Authorized Person _____ **Date** _____ **(WITNESS Signature, *If person cannot sign*)** _____

PAYMENT FOR SERVICE/ASSIGNMENT OF BENEFITS *MUST be signed for every patient who has a third party payor. Name of health department MUST be SPELLED OUT.*

ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to _____ on my behalf, for services I received. I also authorize the local health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third party payors pursuant to KRS 214.420.

☐

I have read the above and have had an opportunity to ask questions. I understand the item checked above as it applies to me. My signature below indicates I do consent, authorize or declare as stated above.

Signature of Patient or Authorized Person _____ **Date** _____ **(WITNESS Signature, *If person cannot sign*)** _____

GENERAL CONSENT FOR HEALTH SERVICES (*expires 1 year from date signed, unless change in custody*):

Of my own free will I consent to care which may include screenings, exams, lab tests, treatments, medicines, x-rays, and any other health service given to me or above named individual by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any exam or treatment on me or above named individual. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed for a diagnosis, to assist in my or above named individual's treatment, or if a health care worker is exposed to my or above named individual's blood, body fluids or tissue as applicable by law.

Signature of Patient or Authorized Person _____ **(WITNESS Signature, *If person cannot sign*)** _____

(Relationship to the patient, If not self) _____ **Date** _____

GENERAL CONSENT FOR HEALTH SERVICES BY FOSTER PARENTS OF MINORS IN CUSTODY OF THE CABINET FOR HEALTH AND FAMILY SERVICES (*valid for 1 year from date signed, unless change in custody/foster parent or invasive procedure required*):

Of my own free will I consent to health services, for the minor child of which is currently in my foster care, given to the above name individual by staff or agents of this health department. ***I understand that I am not allowed to consent to any invasive procedure services as defined by 201 KAR 20:235, Section 1(6) for the above named individual.*** I understand that no Guarantees are being made as to the effect of any exam on the person for whom I am consenting.

Signature of (CHFS) Foster Parent _____ **Date** _____

WIC RIGHTS AND RESPONSIBILITIES (*MUST be signed at every WIC certification and recertification.*)

I have been advised of my rights and obligations under the WIC program. This includes the rights and responsibilities for the eWIC card and any household benefits issued to the cardholder account. I understand that I am also responsible for ensuring the security of the eWIC benefits card and the PIN. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification form is being submitted in connection with the receipt of Federal Assistance. Program officials may verify information on the certification forms. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the state agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law. I have been issued I also understand that my name may be given to other health and welfare programs for eligibility purposes for that program.

Signature of Patient or Other Authorized Person _____ ***Date*** _____

LOUISVILLE METRO
PUBLIC HEALTH & WELLNESS

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

Client Name: (print) _____

Date of Birth: _____

By signing this form, you acknowledge the HIPAA Privacy Notice for the Louisville Metro Department of Public Health and Wellness has been presented to you.

_____

Signature of Client (or another authorized person) Date Signed

For Louisville Metro Department of Public Health and Wellness Use Only

Client refused to sign HIPAA Privacy Notice Acknowledgement

Employee Signature: _____

Date: _____

LOUISVILLE METRO
PUBLIC HEALTH & WELLNESS

HIPAA Privacy Notice

(HIPAA: Health Insurance Portability and Accountability Act)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Your confidentiality is important to the Louisville Metro Department of Public Health and Wellness. We strive to protect the identity and privacy of all our clients' personal health information.

Your Health Care Rights

Patients/clients have the following rights with respect to medical information:

- Receive a written privacy notice
- Ask that only certain parts of your personal health information be given to others
- Withdraw your consent to use health information unless that action has already been taken
- Receive confidential communications of your personal health information
- Correct or add to your personal health information (your request must be in writing, specifying a reason for the changes)
- Review or receive a copy of your personal health information
- Receive an accounting of all who receive your personal health information.

You may file a complaint without cost or penalty if you believe your privacy rights have been violated.

To file a complaint with the Louisville Metro Department of Public Health and Wellness please contact:

HIPAA Privacy Officer, Louisville Metro Department of Public Health and Wellness, 400 East Gray Street, Louisville, KY 40202, Phone: (502) 574 - 8409.

To file a complaint with the Department of Health and Human Services, send your complaint to:

Office for Civil Rights, U. S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201

Responsibilities of the Louisville Metro Department of Public Health and Wellness

Louisville Metro Department of Public Health and Wellness is required by Public Law 104-191 to maintain the privacy of medical information of patients / clients and to provide individuals with notice of our legal duties and privacy practices with respect to medical information. The following describes how we may use or give out medical information about you.

For Treatment

We may give your medical information to our health care staff and other medical providers involved in your care and treatment. EXAMPLE: If we refer you to another healthcare provider, such as a specialist or hospital, we will give your medical information to that provider so they will have the information needed for your treatment or services.

For Payment

We may share medical information about you so we can be paid for services. This may include billing you, your insurance company, or a third party payor. EXAMPLE: We may give your insurance company medical billing information so that we receive payment. We may also provide information about your medical condition to a government program, such as Medicare or Medicaid to determine if that program covers you.

For Health Care Operations

We may share your medical information about you among our staff to carry out our health care operations. This is necessary to maintain a high standard of care. EXAMPLE: Members of our medical staff and the quality improvement team may use information in your health record to review the care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality of health care and service we provide. We may also share your medical information to train our staff and medical/nursing students working at the Louisville Metro Department of Public Health and Wellness.

There are some services in our department through business associates/contact providers. We may share your health information with these agencies so they can perform services requested and bill you or your insurance payer for services provided. These services include lab tests, screening and diagnostic services, and certain other medical services. To protect your health information, we require the business associates/contract providers to safeguard your information in the same manner as we do.

Contacting you

We may contact you by either telephone or by mail at your home or work. You may also be contacted by our automated telephone service that is used to remind you of scheduled appointments, unless you tell us otherwise, in writing.

Research

We may share information with researchers when an Institutional Review Board (IRB) has approved their research. This board reviews research proposals and establishes rules that ensure the privacy of your health information.

Communication with Your Family

Our medical staff, using their best judgment, may share health information necessary for your health and the health and safety of other individuals with the institution and/or its agencies.

Funeral Director/Coroners and Medical Examiners

When required by law, we will release information to funeral directors. We may also provide medical information about you to a coroner or medical examiner to identify a deceased person and determine cause of death.

Parents and Minors

State laws or other laws may decide whether parents will be provided health information on their children. With limited exceptions based on state or other laws, parents control the health information of their children.

Government Agencies

We may share health information about you with a government agency when there is a harmful event with food, supplements, products or product defects.

Persons in Custody/Inmates

If you are or become an inmate of a correctional institution, we may share health information necessary for your health and the health and safety of other individuals with the institution and/or its agencies.

Workers Compensation

We may share health information that is permitted and necessary as required by workers' compensation law related to work related injuries or illness.

Required by Law

We may disclose your health information for law enforcement purposes as required by law including the following:

Public Health Services – Federal and state law requires certain health information to be given to an appropriate health, oversight agency, public health authority, or government agency. The law permits these agencies to collect or receive this information for purposes of preventing or controlling disease and disaster occurrences.

Victims of Abuse, Neglect or Domestic Violence – If we believe you or your child is a victim of abuse, neglect, or violence, we are required to report such information to the appropriate state enforcement agency.

Note: *Except for special situations, we will not use or give out your personal health information for any other purpose, unless you provide written permission. You have the right to withdraw that permission at any time, except if we have already released information from your earlier permission.*

Please direct all questions, comments, or concerns to: HIPAA Privacy Officer, Louisville Metro Department of Public Health and Wellness, 400 East Gray Street, Louisville, KY 40202, Phone: (502) 574 - 8409

The HIPAA Privacy Rule became effective April 14, 2003